

First Aid Advisory meeting June 29, 2011, Room 12, Elihu Harris State Building, Oakland

NAME	Affiliation
Attending in Person:	
Eric Rosance	Phylmar Regulatory Roundtable
Mary Kochie	Cal/OSHA Medical Unit
Kate Smiley	Associated General Contractors
Dr. Bob Harrison	University of California San Francisco/Center for Occ & Env Health
Bob Barish	Cal/OSHA Research and Standards Unit
Bob Nakamura	Cal/OSHA Research and Standards Unit
Mike Horowitz	Cal/OSHA Research and Standards Unit/Moderator
Sean Gillis	EMS Training Officer, Oakland Fire Department
Dr. Linda Morse	Kaiser, San Francisco
Kriste L. Crane	CA State Association of Occupational Health Nurses/JDS Uniphase
Roger C. Delight	Volunteer, County of Sacramento/Elk Grove CERT
Bruce Wick	CA Association of Professional Specialty Contractors/CALPASC
Wendy Holt	Contract Services Administration Trust Fund/CSATF
Ed Calderon	Shea Homes
Steve Johnson	Associated Roofing Contractors
Carol Baracke	Bickmore Risk Control Services
James Mason	Occupational Health and Safety Officer, City of Berkeley
Dr. Dennis Shusterman	Hazard Evaluation System and Information Service/HESIS-CDPH
Taylor Crawford	Student
Attending by Phone:	
Richard Warner	Mercer/ORC Networks
Mary Jean Ryan	CA State Association of Occupational Health Nurses
Cindy Sato	Construction Employers Association
Kendon Dressel, DC	Nibbi Brothers General Contractors
Steve Selig	Cal/OSHA Consultation, Santa Fe Springs
Mike Manieri	Cal/OSHA Standards Board
Jay Weir	Pacific Bell Area Safety Manager
Cheryl Lepley	CA Emergency Medical Services Authority
Cassie Hilaski	Clark Construction
Alan Schuman	Citizen interested in first aid issues, past petitioner

Mike Horowitz started the meeting at 10, checked with people who called in; self-introductions. Mike thanked participants for being involved and for those who had submitted comments on the “food for thought” questions prior to the meeting.

The meeting then started off with the below multiple choice “pop quiz.”

Under current Cal/OSHA first aid regulations, the following is responsible for the adequacy of first aid kit contents:

- a) The consulting physician
- b) The employer
- c) The employees

d) All of the above

The correct answer is (b), the employer, but less than half of those present raised their hands for the correct choice. Horowitz reminded the meeting that, for Cal/OSHA, the employer always has the ultimate responsibility and can be cited.

Horowitz then reviewed the history of the Federal and Cal/OSHA first aid standards. California has always had the consulting physician requirement, while Federal OSHA removed this requirement in 1998. However, Federal OSHA says in its interpretative letters and non-mandatory appendix to 29 CFR 1910.151 that employers may need to consult experts “from the local fire/rescue department, appropriate medical professional, or local emergency room” about first aid kit contents beyond the minimum. At one time, Cal/OSHA had the specific requirements for certain industrial chemicals, e.g. HF and cyanide, but removed them because of the consulting physician input that was supposed to take care of that.

Horowitz mentioned handouts available on a table: petition #519, selected written comments received prior to the meeting; firefighter exposure to cyanide vapors in smoke; 1996 Cal/OSHA memo on consulting physician and prescription drugs in first aid kits; newer first aid methods for cyanide exposure; HF exposure first aid treatment table from Honeywell, minimum kit content list from ANSI, copies of 8 CCR 3400 and 1512 (c); first aid code sections cited in 2005; 8CCR 14300.7 defining list of what is first aid for purposes of record keeping.

Horowitz initiated the discussion by asking what had been the experience of participants in dealing with the consulting physician.

Linda Morse: most small employers are unaware of consulting physician requirement or of most of the other details of the requirements of 3400. The consulting physician requirement is also unnecessary, since the workers compensation definition of first aid is basically what Grandma can do. Minor things like ace wraps and Band-Aids are done with the first aid kit; for more severe injuries the employee should be taken to the clinic or EMS called to the scene. The first aid kit should have disposable gloves. Using the ANSI list makes sense, and every 3 months the kit should be checked to ensure all the required supplies are still there. Employers with special chemical hazards should be required to use physician input, but otherwise keep it simple.

Horowitz asked if the minimal ANSI-specified contents were, in people’s opinion, also adequate for the construction industry.

Morse said one difference was a physically more substantial first aid cabinet was necessary for the construction environment.

Steve Seligman: I’ve found that many small construction employers at most have the identical physician letter of approval (provided by a certain first aid kit purveyor) that has been photocopied over and over again. Instead of requiring a medical doctor’s input, it would be sufficient for the first aid regulation to require input from any licensed health care professional (PLHCP). I question whether other first aid

materials like antidotes are desirable because in an emergency they might be expired and unusable. Keeping antidotes within their expiration dates can be both time consuming and expensive, so time critical things need to be somehow available.

Bruce Wick: There is a tie in here to heat illness. With the refocus provided by 8CCR 3395 on provision of first aid and medical care, there is much greater opportunity to get EMS on site faster, even in fairly remote areas. So employers don't want to be required to do anything complicated regarding first aid measures.

Mary Kochie: I started with DOSH in 1980. Most doctors were community and local; nurses or doctors in plants, they used to walk around the place and know what was there. Clinics hardly ever do that except for very large employers. Recently in what I've seen in the compliance experience is vendors of the supplies provide photocopy sheet with signature of a doctor. There is only compliance with letter of the law.

Horowitz: two people now have mentioned the mimeographed letter. I looked into the qualifications of one such doctor who is signatory to such a letter: the person is licensed in CA but lives in Georgia. In the ANSI standard, they state it is expected that kits would be supplemented by recommendations of someone first aid competent and familiar with workplace unique first aid needs

Sean Gillis: Most small and middle size businesses won't have the antidote for their specialized first aid needs, like for cyanide. Local EMT/paramedic responders probably wouldn't either; it is still unlikely that the EMS will have the right stuff for cyanide; it is unlikely that they would have most specific agents. Employers might have their own, it more likely that NASA or other large employers with their own medical and/or fire department would have physician on staff, and the right supplies.

Kevin Bland: One of the issues is that there is a divergence of unique employment situations as opposed to the majority of employers for whom the ANSI list is adequate and consistent with the original intent of 8CCR 3400.. The standard was probably written when there was less information available, so the need for physician approval has perhaps past. But the employers with specific problems could be addressed through the IIPP. Also, ANSI does not say to talk to doctor, but rather a first aid competent person with familiarity with the first aid needs of that workplace. ANSI is probably best for the vast majority--most employers who do not need a more specialized list. We should not expand the list to include all special industry needs.

Horowitz wanted Kevin Bland to clarify: if you look at the ANSI table and the 1512 table, there is a difference.

Bland said most of the kits may be modeled after either the ANSI list or the OSHA 1512 requirements. ANSI and 1512 are not the same on numbers and types of supplies. It would be nice to have uniformity of the regulations and expectations; it would be better to go with ANSI.

Steve Johnson: Employers want clarity and do not want to be cited for trivial violations of not having the same numbers and types of bandages as the 1512 list. For instance, having just a letter and aspirin might get them cited. They want to have a minimum specified and augment with recommended supplies, not opposed to use of ANSI list, just need to have more consistency about what is needed. If most

employers are using the ANSI kits and it is sufficient, then why not make that the requirement and the basis of citations?

Jim Mason: I agree with Steve Johnson. I have found that small industries have a problem figuring out what they need, the larger employers are more familiar with the regulations and have the resources to get help. Small businesses would benefit from a clear definition of small business first aid kit requirements.

Bob Harrison: It sounds like the start of consensus emerging that there should be a minimum list like the ANSI, with the option to increase as needed, according to expertise for specific hazards, and a third subset for specific hazards that should also be set up, with oversight to be PLHCP or other first aid authority. For antidotes for chemicals, an MD should be required for that, not just a PHLCP because I would be concerned about the proper use of antidotes. The first two levels could be non-medical doctor. Are there any antidotes that need prescriptions to even buy off the shelf? For example, does calcium gluconate require a prescription?

Horowitz asked people in attendance, receiving some general comments that there are several things that are not readily available without prescription.

Roger Delight: Anytime you give someone something to take, it is practicing medicine.

Horowitz said that he wants to go over that issue later. One handout is from Art Sapper which points out the confusion about the issue of what constitutes first aid; this confusion is due in part to how Fed OSHA has defined first aid in a more restrictive way than it is popularly perceived. The ANSI list actually has things on it that are related to practices not on the OSHA list of first aid procedures. So we have to consider that issue. For example, gloves that ANSI requires are not on the 1512 supplies list, and are considered personal protective equipment in the Federal OSHA scheme

Roger Delight added that some first aid measures can be dealt with by protocol but some serious first aid procedures like giving antidotes need special training and maintenance to apply.

Johnson: There seems to be two separate things, general industry and construction. Construction is required to have a first aid trained person on-site, and Red Cross training says wear gloves, so I would support overlaying the ANSI list on the current 1512 list.

Bruce Wick stated he supported some previous comments by Bob Harrison and Mary Kochie, for example, acknowledging that the construction standard requires MD approval. The way first aid kits are sold undermines the credibility of the standard, and Cal/OSHA. I proposes use of the ANSI table so smaller employers can have a list, and the larger employer can rely on the MD for a more specialized approach. It appears there's a consensus on that general concept. I want to deal with the prohibitions, but first get foundation established.

Kate Smiley agrees with Bruce Wick and Steve Johnson on the ANSI list or MD option; I think there is consensus for that part of it.

Horowitz noted that this is not a total democracy but wants to clarify about the 1512 list, is there really consensus for construction about the ANSI list, asks the medical people what they believe should be in

there. For example, the ANSI list does not require tweezers or scissors... are these needed in construction?

Johnson: You don't need scissors to get the clothes off.
Morse stated she supported the use of the ANSI list for 1512.

Bob Barish proposed having a separate appendix for construction to suggest additional possible materials that are non-mandatory, and stated that the flashlight on the 1512 list seems unnecessary.

Wick added that they are concerned about having any medications or prescription materials, but a flashlight is okay...

Horowitz asked if construction people can go to supplier to customize their first aid kits, and should there be a non-mandatory appendix.

Wick said the problem with the appendix idea is that the small employer needs a simple list, and it should not need to be different from the general industry list.

Horowitz said he would be more comfortable with having guidance for additional possible materials, just as Fed OSHA says for small offices the ANSI list is okay to start but that employers must evaluate specific hazards present and consider the resulting possible additions to the first aid kit that might be necessary. Federal OSHA says in their guidance that during an inspection they will also evaluate the first aid kit contents to see if it is really adequate. Horowitz also noted that the quantity of materials that would be in the construction first aid kit has not been addressed. Horowitz said he wants to get participants to review these considerations.

Ed Calderon: At large home construction sites, all the subs may not have kits, although we do, as the General. I really wouldn't want one employee taking a splinter out of the eye of another. He worked at Chevron, and they had antidotes, but there was a fire department and a nurse on site all the time, which is not the case with construction.

Horowitz asked him if he has to review contents of the kit, would you want sterile saline.

Calderon: No, you might flush eye with tap water, but you'd send them out if it doesn't come right out.

Johnson: Looking at the 1512 list, gives an example of why he doesn't like it. If he has crew of 15, but if he adds one guy, he has to add four items that he doesn't need if he simply kept the crew to a size of 15.

Morse said that the additional items are not needed.

Sean Gillis: As far as what makes sense at a construction site, for example, having the supplies necessary to treat a sucking chest wound.

A discussion ensues: Gillis does training with treatment for sucking chest wound, and this type of thing would be very helpful for the injured. Benadryl may also be life saving for anaphylactic reaction. Johnson noted that treating sucking chest wounds crosses over into emergency medical treatment and that these procedures are not addressed in standard Red Cross first aid training. Gillis says having the

equipment necessary to treat sucking chest wounds would not be that complicated; it is key to have basic items for serious problems. For instance, Gillis has changed his mind about having aspirin to treat for heart attack symptom—this is now a standard recommendation for emergency cardiac situations. Similarly, benadryl works well for anaphylactic shock.

Horowitz reads from one of the handouts “What is First Aid?” according to OSHA in the recordkeeping standard, 8 CCR 14300.7: non-prescription med at non-prescription strength; administering tetanus vaccinations; cleaning wounds, using wound coverings; using hot/cold therapy; using non rigid supports; using temporary immobilization devices; drilling of fingernails or toenails to relieve pressure; eye patch use, irrigation of eye or use of swab to remove foreign bodies from the eye; removing splinters from areas other than the eye with tweezers or other means; using finger guards, using massage; drinking fluids for heat stress.

Mike Manieri asked about the disconnect of this list from the usual first aid definition. He thought at first that it should be consistent with training given in first aid class. But this has changed over time, for example AED wasn’t taught in classes a few years ago but it is. Maybe what first aid is is defined in the context of the training received. Also what qualifies as a drug? Manieri also sent in written comments.

Johnson thought there is a difference between field first aid, and industrial or Red Cross first aid; like no training for sucking wound treatment in Red Cross first aid, but perhaps in clinical first aid training.

Mason sees a difference between clinical first aid and field first aid. What we are talking about is field first aid, NOT clinical first aid.

Horowitz noted that the recordkeeping standard is intended to limit what has to be recorded as injuries on the 300 log. Cal/OSHA wants each employer to assess likely injuries in their workplace and prepare for them appropriately with training and suppliers. Employers should have materials and treatment appropriate for their workplace. Noting that 1512 was titled “Emergency Medical Services”, not “First Aid,” Horowitz stated that anything beyond the OSHA list should be considered emergency medical services. So, things like cyanide should be pulled out of that list. Manieri agreed.

Horowitz asked Wendy Holt about the input of consulting physicians in the film and theater industries.

Holt said there are EMTs, who have oversight by physicians, who are on-site, on the set. For example, the EMTs might consult with the physicians about special burn treatments.

Horowitz said that 3400 doesn’t *explicitly* require the employer to evaluate first aid kit contents needs.

Holt replied that she starts from the IIPP hazard evaluation requirement, to have preparations for emergencies like air crashes. Some of the smaller employers would like to have lists, like the construction list; even though it is outdated, it provides guidance. There are some items on the current construction list that might not be necessary.

Horowitz responded that as bigger employers, you have sophistication on using an IIPP approach that smaller employers may not have.

Holt stated her industry would love to have a standard list for compliance like the ANSI list, a minimum list with possible additional materials appropriately required.

Horowitz asked for thoughts about things that should be added beyond the general office list. For example a current Cal/OSHA investigation of small company manufacturing electric cigarettes containing liquid nicotine raises the question whether that employer should stock supplies to counter possible nicotine overdose.

Cassie Hilaski (Clark Construction) asked if a doctor visits the site to go over a non-standard first aid supply list and, like in our case, they have paramedic on site all the time, can the doctor just review the paramedic's list or do they have to go on the site to make the assessment....

Horowitz noted he had provided an internal Cal/OSHA interpretation memo from former Deputy Chief of Health Frank Ciafalo about these requirements; there is no documentation requirement in 8CCR 3400, so how physician approval is to be memorialized is not specified for General Industry. But for construction (8CCR 1512), written approval from the physician is required for additions to the list in the Table, and especially for prescription or non-prescription drugs

Cassie Hilaski: I concur with a physician or someone competent in first aid making the determination. Seems there is hang-up about emergency medical services. A person (attending to an injured employee) is going to worry about what to do until the EMS gets there. It's not good to go by specific recordable first aid categories and actions; we need to allow for the desire to provide assistance.

Sean Gillis: First aid rules should focus on life-saving care, and not so much on getting splinters out. It is a considerate thing to have guidance about splinter removal, but Cassie Hilaski has raised the issue of "time- to- treatment," for example there is revival of the acceptance of tourniquets to stanch severe bleeding. So it is smart important to address "time-to treatment" for serious situations rather than focus on minor first aid. In the case of heart attacks, things like providing aspirin can be helpful in bridging the time-to-treatment gap.

Roger Delight: My picture of first aid in construction is 20-30 trucks rolling around with kits in them subject to heat and other spoilage. Maybe there should be a central one.

Ed Calderon agreed, stating that on his company's project the general contractor does maintain a central first aid kit even if subcontractors have their own kits.

Bob Harrison agreed that there should be some lifesaving items required, but there has to be training on how to use it effectively. For example, aspirin will not be recognized by everyone as something to utilize for a heart attack, so people need to know how to use it. The same for a tourniquet.

Ed Calderon said there should be an option, not a requirement to have everything possible in the kit for "time-of-treatment" interventions.

Bruce Wick acknowledged that construction is a hazardous industry, but in the last two decades, with new communication devices, the emphasis has increasingly become to get the person to emergency medical care or EMS as soon as possible. So the first aid kit should focus on what the first aid trained people have been trained to do with the rest of the focus on assuring fast 911 response. Also need to

have the procedures for injured to get access to care, or vice versa. There is a need to say how the first aid trained people can do some additional augmented potential life-saving items that they could be trained on, but that is beyond the first aid requirement. All kits should not be that different from each other.

Christy Crane: I wanted to go back to Bruce's suggestion to use the ANSI list to substitute for the list in 1512. The regulation should also have a non-mandatory list for higher hazard and remote locations and a non-mandatory list with aspirin and similar treatments.

Steve Johnson added that the mandatory and non-mandatory lists should be clearly presented in the regulation, with the non-mandatory list right below the mandatory list.

Carol Baracke concurred. I do lots of work with public agencies and mobile work crews who have first aid kits that include things for coverage of regional emergency preparedness as well as for regular first aid. Critical public operations would require more items and more complex kits with more things, and it is important to offer options to be multi-functional. Then the employer has more leeway and options to deal with emergencies. Baracke said there should be a clear core list and guidance for other specific industries.

Bob Barish noted that such non-mandatory more critical supplies are something that go towards meeting the Injury and Illness Prevention Plan expectations and mandate to assess hazards and prepare to respond to them. He suggested having a semi-mandatory recommendation to tie in first aid needs with the problems identified through the IIPP.

Horowitz noted that some of these critical supplies are like the contents of earthquake kits.

Kriste Crane said another example of linkage similar to Bob Barish's suggestion would be to require employers to follow the MSDS-listed first aid recommendations to decide on contents.

Horowitz noted that some MSDS first aid recommendations are not very accurately or specifically prepared.

Carol Baracke noted that following MSDS guidelines is required by the emergency action plan. Other commenters agreed that the Hazard Communication regulation requires attention to MSDS first aid recommendations.

Horowitz wanted to go over the physician approval of prescription vs. non-prescription items, like anti-burn gel, and whether any such items should receive blanket approval in a revised regulation.

Jay Weir said that at Pacific Bell, all of their first aid kits are approved by physicians.

Sean Gillis wanted to submit the list from Oakland's Emergency Medical Dispatch which is a diagnostic tool for 911 responders, an algorithm utilized to suggest pre-EMS arrival treatment. For example, aspirin for heart attack and benadryl for an allergic reaction.

Horowitz asked about the epi-pen.

Wendy Holt noted that epi-pens require prescriptions.

Steve Seligman noted in regard to the flashlight included in the 1512 list that flashlights are important for work at night—not always in regard to first aid but they can be important for safety as during egress from a building during an emergency such as a fire or earthquake when you can't otherwise see. In his Cal/OSHA work, Seligman often cites the 8CCR 3215 Means of Egress requirement for a safe means of egress if flashlights are not available.. It's good to have performance issue like this where it is necessary to evaluate tools that will be used. Seligman opined that it may necessary for some places of employment to have cyanide treatment kits, and if they did this would require additional training for; employees. If there are injectables in such a cyanide kit, 8CCR 5193 (Bloodborne Pathogens regulation) might apply. Which brings to mind, even giving someone a band aid from the first aid kit in the lunchroom could be an item needing to be addressed under 5193.

Dennis Shusterman asked about the cyanide treatment, recalling that in the K&L Plating cyanide fatality in Oakland in 1993 the victims were pulled out of the confined space and doused with water but didn't one didn't revive; not having CPR was the issue. This need to have CPR trained individuals may be a special case for places of employment with cyanide exposure potential—at least CPR must be available for cyanide victims until EMS arrive. Shusterman recalled that amyl nitrite used to be a Title 8 requirement for workplaces with cyanide exposure, but he wanted to ask if the reason the requirement was removed was due to the potential for the amyl nitrite to be utilized as a recreational drug.

Horowitz stated that while recreational usage might have been a factor, the official reason the requirement was removed was because it was considered duplicative of the consulting physician requirement. He noted that emergency treatments for cyanide like amyl nitrite and calcium gluconate for hydrofluoric acid exposures would have to be discussed separately from first aid kit contents, as these should not properly be termed first aid supplies per se, but were in fact better viewed as pre-hospital treatments. Horowitz asked if it wasn't true that some of the current treatments for cyanide exposure need an intravenous administration and so therefore would require much more training.

Sean Gillis noted that sodium thiosulfate, one of the cyanide antidotes, is carried by Alameda County ambulances, but it is an IV procedure and it is hard to administer. On the other hand, an employer could maintain restricted access to amyl nitrite, which does not require substantial training in order to administer.

Horowitz noted that in 2006, after approval by the FDA of the hydroxocobalamin cyanide antidote kits, many firefighting authorities wanted it because they were being exposed to cyanide during overhaul as well as were fire victims trapped in the fire. So fire fighters were pushing for it because it was very effective and had fewer adverse effects than other cyanide antidotes.

Sean Gillis said hydroxocobalamin is a treatment for smoke inhalation but it is not easy to administer, so most fire department ambulances don't carry it.

Horowitz asked who approves Emergency Medical Services Authority (EMSA) list of materials to be carried by ambulances.

Sean Gillis noted that there are scope of practice issues county by county that influence what the Local EMSA puts on the mandatory ambulance equipment list.

Cheryl Lepley of California State EMSA said Local EMSAs set the list for their counties. Gillis added that even though acquiring a physician signature for specific medications may be burdensome to some counties, there can be a need to have the review.

Horowitz asked if Local EMSAs will review with employers in their county the specific pre-hospitalization medical needs that an employer might need to stock so as to be available to an ambulance responding to an emergency.

Cheryl Lepley said some Local EMSAs will do that, or example where employers have specific needs, or if individuals at a worksite have specific individual needs, and the paramedics who will respond need to know how to administer a particular medicine for that individual or worksite need.

Horowitz asked about snake bite antidotes as part of ambulance supplies.

Lepley said yes, some ambulances carry them in regions where snake bites are common.

Horowitz asked the group if they have heard of a multi venom treatment administered by injection; no one had.

Kate Smiley related how AGC members who do wind turbine work have to account for presence of snakes; they have to decide in advance how to deal with the snake hazard. We need to refer back to what employers should do; we need a baseline in the regulation.

Horowitz asked if the AGC employers stock the anti-venom in their first aid kits. Smiley said no, these employers would make arrangements with 911 responders to carry the anti-venom.

Horowitz asked if there was any more discussion about grandfathering certain antidotes or about OTC drugs.

Mary Kochie asked about the current first aid training course given by Red Cross, whether or not it covered burn salves. Steve Johnson replied that no, the Red Cross training does not cover this topic. So, Mary asked, why are burn salves in the first aid kit when for 20 years Red Cross has recommended the use of cool water as treatment for burns.. It was my understanding that such burn salves were not recommended for first aid treatment because the salve can hold the heat in.

Mike noted that it was the ANSI 308.1 standard that includes burn salve, not Red Cross training.

Bruce Wick said that the kit should reflect what people are trained to do, and Red Cross training should be the controlling factor.

Mary Jean Ryan stated that she concurred that there shouldn't be any medications in the kit. Mike mentioned antiseptics, etc. These are not needed for immediate first aid; if you allow them you get into allergy and other liability issues. The existence of medications in the kit suggests the employer's first aid trained individual is a medical provider. If a specific workplace has a chemical requiring an antidote, then this should be permitted with doctor consultation.

Horowitz said this statement makes sense, but he has been hearing for years that employers want to buy the ANSI kit, not get things piecemeal.

Mary Jean Ryan said that ANSI kit is the lesser of two evils, most of the treatment materials will not harm people. It was probably OK if the ANSI standard lists a first aid product, but she still believes it's best not to have any medication whatsoever in the kit. One can have problems with allergies and sensitivities. In regard to first aid, we just want to do the basics. If anything else goes into the kit, then this expands what first aid person will try to do.

Bob Harrison said we should review the ANSI list, and if we'll find that it is probably 80% OK but could probably use a little tweak...So would adding a few additional requirements be a problem?

Bruce said probably not, employers could just pull things out. But for materials additional to those on the ANSI list, there could be a problem. It depends on what the first aid training conflict might be, if anything were added to the kit. Most employers want to do the minimum.

Bob Harrison said to make this discussion more concrete so what about adding tweezers or a tourniquet?

Wendy Holt said the boxes that first aid kits are sold in are made to fit the supplies, so adding things might be a problem

Bruce Wick said the emphasis is on the Cal/OSHA requirement, not ANSI, and, he noted, California is the biggest medical market, so sellers will make Cal/OSHA compliant kits.

Horowitz noted in contrast that in so far as he was aware, no commercial kits have been made according to the current California construction list from the Table in 8CCR 1512.

Kevin Bland said that even though California is a large market, it still may be only 10% of the total US market.

Bob Barish asked, relative to the first aid training requirement, does the training have to be renewed?

Wendy Holt said that the Red Cross card has to be renewed every 2 years. Bruce Wick and Steve Johnson noted that Cal/OSHA compliance officers will give citations if a first aid or CPR card is not current.

Kevin Bland said that the renewal may be offset by having overlapping responsible first aid persons.

Bob Barish wanted to clarify, so there is always someone with current first aid training on the construction job site?

Bruce Wick said that is the understanding.

Horowitz noted that in the General Industry regulations, first aid training is not specifically required for the majority of employers—just those at remote locations.

Someone on the phone asked about the access to Emergency Medical Services time.

Mary Kochie noted Dr. Howard's 4 minute rule for EMS response—a guideline to determine if such response was timely enough or if first aid and CPR trained individuals were required. Close proximity to rapid EMS response is something difficult to prove in practice, she said.

Horowitz asked, regarding OTC items, should there be a class of items that people might want to add to the kit—even if unnecessary—but that could be listed as exempt from requiring physician or LHCP approval. He read some of the items that were included in his family's earthquake preparedness first aid kit, asking for each the opinions of the attendees:

Alcohol pads--OK, without approval

Iodine prep pads—should be left out of kit, these are not recommended anymore due to shellfish allergy reaction.

Antiseptic towelettes--OK

Antibiotic pads, et.--OK, if an allergic reaction to the antibiotic does occur, it will be a delayed reaction

Horowitz noted that he recently learned during an Emergency Room visit that the current best practice for cleaning wounds and preventing infection is the application of water for sufficient duration, without the application of antibiotics.

Richard Warner noted that there might be a problem of people adding too many things to the kits if all OTC drugs were permitted without PLHCP input.

Linda Morse noted that 24-percent of the US population has metabolic syndrome, so they are 6 times more susceptible to heart attack therefore first aid kits should have aspirin for early treatment in the field. It is pretty well established that early administration of aspirin is efficacious.

Horowitz added that you would need to specify that aspirin was in the first aid for the specific purpose of treating suspected heart attacks, and the aspirin would have to be the correct dose for this purpose.

People in attendance agreed, generally. Mary Kochie noted that the ANSI first aid standard specifies that contents must be individually packaged in single dose packages. The regulations should specify that the aspirin must be low dose baby aspirin.

Wendy Holt asked about the population that may have an adverse reaction to aspirin. The general response from the medical professionals present is that this is a very small group.

Mary Kochie suggested that there is some wisdom to the ANSI decision to not having tweezers as part of kit contents because of concerns of blood- or MRSA-contaminated tweezers being placed back in the kit after use without adequate cleaning. So if Cal/OSHA should continue to require tweezers, as it now does on the Table in 8CCR 1512, then disposable single-use tweezers should be specified.

Steve Seligman returned to the issue of the blood thinning effects of aspirin. He stated the employer shouldn't necessarily be required to be responsible for non-occupational medical incidents like a heart attack. Perhaps this aspirin issue is related to AED use. There shouldn't be anything in the kit to ingest or inject that could be misused. Possibly we could have exceptions for things like antiseptics, provided

there is training on their use. Employers need to be careful that the only things in a first aid kit are items that employees have been trained on.

Linda said that blood thinning is the therapeutic effect necessary for heart Myocardial Infarcts, and the earlier the aspirin is given, the better the results.

Sean Gillis said if Cal/OSHA required baby aspirins in first aid kits, there would be great public health effect...

Bob Barish noted that medical directions from 911 are not always available when needed during an emergency. But, he asked, is there an option for subscription services for the same kind of service, like Chemtrec provides regarding MSDS? No one knew of that kind of service.

Kevin Bland noted that Section 1511 already addresses the most needs, requiring the employer to make a thorough site survey of predictable hazards. It is hard to have a standard that would cover everything, Hazcom already addresses chemical exposures. Over the counter items, should not be included with the first aid items, even aspirin. Just as for AEDs, these things should not be required, but employers should make a decision. Employers should decide about things that are ingested or injected. Topical things and irrigants are okay. Special hazards like snakes are covered under Section 1511.

Alan Schuman said he agrees with Kevin Bland: Medical oversight on some first aid items is necessary to make sure of appropriate and safe use.

Mike said that the comments made today and recommendations will be sent out to participants. Participants will also be notified if there are to be any suggested changes for 1512 and 3400,

The meeting adjourned at 1235.